EARLY HEAD START
TIP SHEET
No. 21

What do we mean by continuity of care in out-of-home care settings?

Response:
Continuity of care is an important way to help babies develop secure relationships with caregivers. Ron Lally, Director of the Center for Child & Family Studies, WestEd writes, "The concept of *continuity of care* refers to the policy of assigning a primary caregiver to an infant at the time of enrollment in a child care program and continuing this relationship until the child is three years old or leaves the program." Combined with primary caregiving (the process of assigning one caregiver to a child or small group of children to serve as the primary source of care) and small groups, continuity of care provides the time and intimacy babies need to learn about themselves and form meaningful relationships.

Possible Approaches
Continuity of care, between a child care provider and a baby, may be achieved in several different ways. The two most important elements involved in continuity of care approaches are 1) the day to day interactions between the primary caregiver and the baby that give the baby a sense of predictability in their daily experiences and 2) the deepening relationship and shared memories created through the enduring, year-after-year relationship between the primary caregiver and the baby. The extended time together supports a child's development of a sense of history of themselves with the caregiver. It helps babies believe that people remain in their lives, in caring, meaningful ways -- that they can rely on, and safely love other people. For families experiencing multiple challenges (e.g., unstable housing leading to multiple moves, unstable employment, or numerous adults or other individuals rotating in and out of the home), continuity in the caregiving environment is especially beneficial for the young child, who might not otherwise experience regularity in relationships.

When continuity of care is provided by a primary caregiver, there are also many opportunities for the caregiver and parents to develop a caring relationship. Caregivers may learn from parents how the baby expects to be cared for, and any cultural or personal care practices the family utilizes. The caregiver, in turn, may inform the family on the thinking behind some of the care practices in the program. Open, genuine communication between parents and caregivers increases the continuity of the baby's experiences between home and center.

Different structures for continuity of care include mixed age groups of infants and toddlers together, nurtured by primary caregivers throughout their first three years, similar to the design of family child care. Another model is remaining with the same children in a close age group and as the children grow older, moving to a new, age- appropriate space with the same caregiver, providing the caregiver (and child) the opportunity to form long-lasting bonds. As time progresses, caregivers in this arrangement work with various age groups over several years. A third method is to maintain a close age group with the same caregiver but modify the environment as the children's abilities and interests change.

While some caregivers may feel more competent with specific age groups and prefer to work only with young infants or only with two year olds, the caregiver and baby will reap mutual benefits from a more long term relationship spanning the duration of the child's enrollment. The caregiver can feel confident of their ability to *really know* a child, to be able to read each baby's cues, and to know how to individually comfort and challenge each baby. The caregiver avoids the stress of constantly "learning" new babies.

The case for continuity

A system of continuity of care helps to nurture the important relationships between primary caregiver and the child. It is within the context of these relationships that children grow and develop.

> *When young children and their caregivers are tuned into one another, and when caregivers can read the child's emotional cues and respond appropriately to his or her needs in a timely fashion, their interactions tend to be successful and the relationship is likely to support [the child's] healthy development in multiple domains, including communication, cognition, social-emotional competence, and moral understanding. (National Research Council and Institute of Medicine, 2000, p. 28)*

Babies actively use every moment with other people, every sense, and every feeling, to understand their own experience and their own identity. By creating physical pathways in the brain, babies develop a mental model for how they see themselves and the world. They watch adults and learn how people act in different situations, how people act toward them, and how people express their emotions. They learn whether they can trust adults to understand what interests and excites them or how to help them be calm. They learn whether the world is predictable or not. They learn whether they can trust adults to keep them safe.

Because babies learn these important things through many repeated moments of experience, it takes much effort and a long time for a baby to really develop ideas about who they are and what to expect of others. When their caregivers are constantly changing, babies may decide that it is too hard to keep learning about new people, and too painful to repeatedly fall in love and be disappointed by their leaving. They may learn that relationships are superficial and transitory experiences. Recent studies of stress and hormone levels in the brain demonstrate that toddlers who have experienced sensitive, responsive, secure relationships can manage stressful situations without producing potentially damaging levels of cortisol. Good, predictable, dependable relationships help infants to manage challenging circumstances in other areas of their lives.

Considerations:

- What does the program staff understand about the process of early learning and early relationships?
- What kinds of trainings does the program offer about continuity of care and primary caregiving?
- How do the organizational structure and personnel policies of the agency support continuity of care?
- How does the staff feel about working with restricted or expanded age groups?

- Does the staff have the range of skills needed to work with mixed age groups or the range of the first three years of life?
- How does the program support children and families when caregivers or home visitors leave?
- How do licensing or accreditation requirements impact the plan for continuity?
- How can the program modify the physical environment in the classroom to allow for continuity?

Performance Standards, Title 45, Code of Federal Regulations:

- 1304.20(f)(1) Grantee and delegate agencies must use the information from the screening for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs.

- 1304.21(a)(1)(i)(iii) In order to help children gain the skills and confidence necessary to be prepared to succeed in their present environment and with later responsibilities in school and life, grantee and delegate agencies' approach to child development and education must:
    i. Be developmentally and linguistically appropriate, recognizing that children have individual rates of development as well as individual interests, temperaments, languages, cultural backgrounds, and learning styles.
    iii. Provide an environment of acceptance that supports and respects gender, culture, language, ethnicity and family composition.

- 1304.21 (a)(2)(i-ii) Parents must be:
    i. Invited to become integrally involved in the development of the program's curriculum and approach to child development and education
    ii. Provided opportunities to increase their child observation skills and to share assessments with staff that will help plan the learning experiences.

- 1304.21(a)(3)(i)(A-E) Grantee and delegate agencies must support social and emotional development by:
    i. Encouraging development which enhances each child's strengths by:
        A. Building trust;
        B. Fostering independence;
        C. Encouraging self-control by setting clear, consistent limits, and having realistic expectations;
        D. Encouraging respect for the feelings and rights of others; and
        E. Supporting and respecting the home language, culture and family composition of each child in ways that support the child's health and well being.

- 1304.21(a)(4)(i) Grantee and delegate agencies must provide for the development of each child's cognitive and language skills by:
    i. Supporting each child's learning, using various strategies including experimentation, inquiry, observation, play and exploration.

- 1304.21(b)(1)(i-iii) Child development and education approach for infants and toddlers. Grantee and delegate agencies' program of services for infants and toddlers must encourage:
    i. The development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and whenever possible, speak the child's language.
    ii. Trust and emotional security so that each child can explore their environment according to his or her developmental level and
    iii. Opportunities for each child to explore a variety of sensory and motor experiences with support and stimulation from teaches and family members.

- 1304.21(b)(2)(i-ii) Grantee and delegate agencies must support the social and emotional development of infants and toddlers by promoting and environment that:
    i. Encourages the development of self awareness, autonomy, and self expression; and
    ii. Supports the emerging communications skills of infants and toddlers by providing daily opportunities for each child to interact with others and to express himself or herself freely.

- 1304.23(b)(4) Parents and appropriate community agencies must be involved in planning, implementing and evaluating the agencies' nutritional services.

- 1304.23(c)(5) Infants are held while being fed and are not laid down to sleep with a bottle.

- 1304.24(a)(1)(i-vi) Grantee and delegate agencies must work collaboratively with parents by:
    i. Soliciting parental information, observations, and concerns about their child's mental health;
    ii. Sharing staff observations of their child and discussing and anticipating with parents their child's behavior and development, including separation and attachment issues;
    iii. Discussing and identifying with parents appropriate responses to their child's behaviors;
    iv. Discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program;
    v. Helping parents to better understand mental health issues; and
    vi. Supporting parents' participation in any needed mental health interventions.

- 1304.40(a)(1) Grantee and delegate agencies must engage in a process of collaborative partnership- building with parents to establish mutual trust and to identify family goals, strengths and necessary services and other supports.

- 1304.40(d)(2) Early Head Start and Head Start settings must be open to parents during all program hours. Parents must be welcomed as visitors and encouraged to observe children as often as possible and to participate with children in group activities.

- 1304.40(e)(1)(3) Grantee and delegate agencies must provide opportunities to include parents in the development of the program's curriculum and approach to child development and education. Grantee and delegate agencies must provide opportunities for parents to enhance their parenting skills, knowledge, and understanding of the educational and developmental needs and activities of their children and to share concerns about their children with program staff.

- 1304.52(g)(4) Grantee and delegate agencies must ensure that each teacher working exclusively with infants and toddlers has responsibility for no more than four infants and toddlers and that no more than eight infants and toddlers are placed in any one group.

Resources:

Early Head Start National Resource Center. (July 25, 2001). *Maintaining relationships: Continuity in Early Head Start and Migrant and Seasonal Head Start programs (audiocast).* Available on the web at http://www.vodium.com/mediapod/zerotothree/audioconference/

Gunnar, M. (1998) *Quality of care and the buffering of stress physiology: Its potential role in protecting the developing human brain*. Newsletter of the Infant Mental Health Promotion Project, (21), University of Minnesota: Minneapolis

Howes, C. (1991) *Infant Child Care*. ERIC Digest (EDO-PS-91-6), ERIC Clearinghouse on Elementary and Early Childhood Education, University of Illinois at Urbana-Champaign

Lally, J.R. & Signer, S.M. (Accessed December, 2003) *Introduction to Continuity*. WestEd, The Program for Infant Toddler Caregivers

National Research Council and Institute of Medicine (2000), *From neurons to neighborhoods: the science of early childhood development.* J.P. Shonkoff and D. Phillops, (Eds.), Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

Needleman, R. (2003) *Continuity of Care: Why it's so important*. http://www.drspock.com/article/0,1510,4393,00.html?r=related

Parlakian, R., & Seibel, N.L. (2002). *Building strong foundations: Practical guidance for promoting the social-emotional development of infants and toddlers.* Washington, DC: ZERO TO THREE.

This Tip Sheet is not a regulatory document and is for internal use only. Its intent is to provide a basis for dialogue, clarification, and problem solving among Regional Offices and grantees. If you need further clarification on Head Start policies and regulations, please contact your Regional Program Specialist.